MDR Tracking Number: M5-04-0410-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 10-09-03.

The IRO reviewed muscle testing, office outpatient visits, therapeutic exercises and ROM measurements rendered from 03-31-03 through 05-05-03 that was denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $650.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. The physical therapy services were medically necessary up to three times per week; follow up office visits were medically necessary once every two weeks. Also medically necessary were the muscle testing and ROM measurements. Office visits in excess of once every two weeks and physical therapy in excess of three times per week were not found to be medically necessary. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 02-03-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
3-25-03 and 04-14-03 (2 DOS)	97750-MT	$86.00 (1 unit @ $43.00 X 2 DOS)	$0.00	G	$43.00	96 MFG MEDICINE GR (I)(E)(3)	Not global to any other service billed on dates of service. Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of $43.00 X 2 DOS = $86.00
TOTAL		$86.00	$0.00				The requestor is entitled to reimbursement in the amount of $86.00

This Decision is hereby issued this 16th day April 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 03-25-03 through 05-05-03 in this dispute.

This Order is hereby issued this 16th day of April 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/dlh

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

January 22, 2004

Re: IRO Case # M5-04-0410 amended

Texas Worker's Compensation Commission:

___has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Physical Medicine and Rehabilitation, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

History

The patient is a 41-year-old male who injured his left hand in ___ when an 8,000-pound double reel rolled across his left hand, causing a fracture of the fifth metacarpal. The patient underwent open reduction and internal fixation emergently. The patient followed up with a chiropractor as his treating doctor. The percutaneous pins were removed from the patient's left metacarpal on 2/28/03. The patient was then started in physical therapy for range of motion and strengthening of the left hand and wrist.

Requested Service(s)

MT muscle testing, office outpatient, therapeutic exercises, ROM measurements

Decision

I agree with the carrier's decision to deny the requested physical therapy services in excess of three times per week, follow up office visits in excess of once every two weeks. I disagree with the decision to deny the other requested services.

Rational

The testing was medically necessary to evaluate the patient's progress as he recovered from his injuries. Physical therapy, including therapeutic exercises following removal of percutaneous pinning was medically necessary to restore range of motion and strength in the hand and wrist. However, no more than three sessions per week would be necessary in a case such as this. It appears that office visits were billed at an excessive frequency. It would not be medically necessary to have office visits more than every two weeks to follow the patient's progress in his physical therapy program.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.